STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G217	A. BUILDING _____ B. WING _____	07/28/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RCM OF WASHINGTON, INC	617 DAHLIA STREET, NW WASHINGTON, DC 20011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 000	INITIAL COMMENTS On May 20, 2009, the Health Regulation Administration (HRA) received an incident report via fax transmittal. According to the incident report, Resident #1 was on a routine appointment at a wound care clinic that day when clinicians observed signs/symptoms of infection on the client's right heel. The resident was taken to a hospital emergency room for evaluation, and was subsequently admitted. He was discharged from the hospital on June 9, 2009 and returned home. On July 27, 2009, HRA initiated an onsite investigation to determine compliance with federal and local standards of care with respect to the provision of health care, wound care and prevention and the establishment and implementation of policies and procedures designed to ensure client health and safety. The findings of this report were based on observation of Resident #1, interviews with nursing staff, direct support staff and administrative staff as well as the review of the resident's medical and physical therapy records. In addition, the resident's incident reports and corresponding investigation reports also were reviewed. It should be noted that Resident #1's health care and habilitation services had been reviewed during a March 19, 2009 annual recertification survey.	I 000	Received 9/16/09 GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF HEALTH HEALTH REGULATION ADMINISTRATION 825 NORTH CAPITOL ST., N.E., 2ND FLOOR WASHINGTON, D.C. 20002	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record	I 422		

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I 422	Continued From page 1 review, the facility failed to ensure that residents were repositioned in accordance with their repositioning schedule, as prescribed, for the one resident with multiple pressure sores out of five total residents. (Resident #1) The findings include: On July 27, 2009 at 8:35 a.m., Resident #1 was observed lying in bed, positioned on his back facing the ceiling. At the time, there was an LPN and at least two direct support staff on duty in the facility. The LPN stated that she had been on duty since approximately 8:00 a.m. that morning, in accordance with her scheduled shift. According to staff, and later verified through record review, Resident #1 was totally dependent on staff for repositioning. At approximately 8:50 a.m., the house manager arrived in the facility. At 8:55 a.m., someone closed the resident's bedroom door as this surveyor walked towards the door. The resident's position at that time was not determined immediately. At approximately 9:30 a.m., the LPN stated that the resident had a wheelchair and he was sitting in it at that time. [This was confirmed through observation.] She further indicated that there was an established schedule for repositioning him around the clock. Staff used the same positioning schedule every day. At approximately 4:55 p.m., review of a repositioning schedule posted on a wall next to the resident's bed revealed that he should have been transferred from his bed into his wheelchair at 8:00 a.m. His orders were to have him repositioned every two hours. Beginning at approximately 4:57 p.m., the QMRP and the supervisory RN were asked about the	I 422	All staff were inserviced on client #1's repositioning on Refer to attachment #1 The repositioning form was revised by the facility RN. The RN did add the comment section in the event that there is discrepancy in repositioning time. Refer to attachment #2 In the future, the facility will ensure that client #1 is repositioned, and that any discrepancy in time is documented; in addition, the facility will only maintain one log book. It can be noted that the staff closed the door for privacy as they were about to provide care to client #1.	7-29-09 9-11-09

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I 422	Continued From page 2 repositioning schedule. To their knowledge, staff had been adhering to the posted schedule. They were not aware of any delays or variations in his repositioning. After hearing that the resident had been observed in his that morning after 8:30 a.m., the RN telephoned the house manager to ask about it. She confirmed that he had been in bed at the time she arrived that day. Direct support staff had just returned to the facility from the morning van run to residents' day programs. They closed his bedroom door for privacy during personal hygiene care and then placed the resident in his wheelchair afterwards. At approximately 5:12 p.m., review of two log books that were being maintained simultaneously by direct support staff revealed that neither log required staff to document the time that they actually performed the repositioning. Instead, the log sheets had a designated time and position already noted. Staff only had to place their initials in a space next to that repositioning. Review of the log sheet for that morning revealed that staff had placed their initials next to the 8:00 a.m. wheelchair repositioning, even though observations and interviews had shown that the resident remained in bed until 8:50 a.m. or shortly thereafter. The QMRP and the RN acknowledged that they would not have known about the discrepancy in repositioning time had it not been brought to their attention by this surveyor. After more discussion, the QMRP and the RN acknowledged that the current method used by staff to document repositioning did not ensure accurate data for quality assurance purposes. It should be noted that Resident #1 had pressure sores on the sacrum, right hip and left hip. A July 16, 2009 report from the wound clinic indicated	I 422	All staff were inserviced on client #1's repositioning on 7-29-09 Refer to attachment #1 The repositioning form was revised by the facility RN. The RN did add the comment section in the event that there is discrepancy in repositioning time. 9-11-09 Refer to attachment #2 In the future, the facility will ensure that client #1 is repositioned, and that any discrepancy in time is documented; in addition, the facility will only maintain one log book. It can be noted that the staff closed the door for privacy as they were about to provide care to client #1.	

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I 422	Continued From page 3 that those three wounds were improving. There was no change with the fourth wound (right heal). It should be further noted that the physical therapist had determined 9 months earlier, in October 2008, that the seating system in the resident's wheelchair did not meet the resident's needs.	I 422		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: 1. Based on observation, interview and record review, the facility failed to ensure the resident's right to receive a custom seating system suited to his assessed needs, for the one resident in the sample. The findings include: On July 27, 2009 at 9:30 a.m., Resident #1 was observed seated in a wheelchair in his bedroom. There were pillows placed between both sides of his torso and the right and left sides of the chair. Beginning at 12:31 p.m., review of the resident's physical therapy (PT) documents revealed that on November 17, 2008, the PT recommended a "new custom seating system" for his wheelchair. The PT then submitted an assessment tool dated December 29, 2008 that provided specifications regarding the wheelchair molding. Attached was a December 28, 2008 Functional Mobility Evaluation on which the PT wrote "The seating system is oversized and does not support him.	I 500	719-A form was sent to essential Rehab on 6-10-09; however, Essential did not deliver the wheelchair due to the fact there was no record of the age of the wheelchair. Refer to attachment #3 A 719-A form was completed, and sent to Essential Rehab Refer to attachment #4 In the future, the facility will ensure that client #1 is provided with the adaptive equipment on a timely manner as prescribed by the PT.	9-14-09 d

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I 500	Continued From page 4 The frame is oversized and forces malalignment <sic>." Beginning at approximately 11:40 a.m., review of the qualified mental retardation professional's (QMRP's) monthly notes revealed for the period January 2009 - June 2009 revealed no references made to the wheelchair and there was no written documentation of efforts made to secure the new seating system. At approximately 1:15 p.m., the Director of Nursing and the QMRP were asked about the status of the custom-molded seating system for the resident's wheelchair. They stated that as of July 27, 2009 he was without the new seating system. A form 719A reportedly had been submitted; however, they could not recall the exact date. They agreed to search for documentation. On July 28, 2009 at 10:35 a.m., the house manager stated that she had instructed staff to hand deliver a 719A form to the PCP's office; this reportedly was achieved on or around July 15, 2009, eight months after the PT recommendation. No written documentation was made available for review before the investigation ended at 5:10 p.m. that evening. It should be noted that in addition to the pressure ulcer on his right heel, Resident #1 was receiving treatment for a pressure ulcer on his right hip, another ulcer on his left hip and yet another pressure ulcer on his posterior sacral area. 2. Based on observation, interview and record review, the facility failed to develop and implement a system to ensure that Resident #1	I 500	719-A form was sent to Essential rehab on 6-10-09; however, Essential Rehab did not deliver the wheelchair due to the fact that there was no record of the age of the wheelchair Refer to attachment #3. Another 719-A form was completed, and sent to Essential Rehab on Refer to attachment #4 In the future, the facility will ensure that client #1 is provided with the adaptive equipment on a timely manner as prescribed by the PT.	9-14-09

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I 500	Continued From page 5 was repositioned in accordance with his prescribed repositioning schedule. The findings include: Cross-refer to I422. On July 27, 2009 at 8:35 a.m., Resident #1 was observed lying in bed, positioned on his back facing the ceiling. At approximately 4:55 p.m., review of a repositioning schedule posted on a wall next to the resident's bed revealed that he should have been transferred from his bed into his wheelchair at 8:00 a.m. His orders were to have him repositioned every two hours. Beginning at approximately 4:57 p.m., the QMRP and the supervisory RN were asked about the repositioning schedule. To their knowledge, staff had been adhering to the posted schedule. They were not aware of any delays or variations in his repositioning. Review of the log sheet for that morning revealed that staff had placed their initials next to the 8:00 a.m. wheelchair repositioning, even though observations and interviews had shown that the resident remained in bed until 8:50 a.m. or shortly thereafter. The QMRP and the RN acknowledged that they would not have known about the discrepancy in repositioning time had it not been brought to their attention by this surveyor. After more discussion, the QMRP and the RN acknowledged that the current method used by staff to document repositioning did not ensure accurate data for quality assurance purposes.	I 500	All staff were inserviced on client #1's repositioning on Refer to attachment #1 The repositioning form was revised by the facility RN. The RN did add the comment section in the event that there is discrepancy in repositioning time. Refer to attachment #2 In the future, the facility will ensure that client #1 is repositioned, and that any discrepancy in time is documented; in addition, the facility will only maintain one log book. It can be noted that the staff closed the door for privacy as they were about to provide care to client #1.	7-29-09 9-11-09

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W 000	INITIAL COMMENTS On May 20, 2009, the Health Regulation Administration (HRA) received an incident report via fax transmittal. According to the incident report, Client #1 was on a routine appointment at a wound care clinic that day when clinicians observed signs/symptoms of infection on the client's right heel. The client was taken to a hospital emergency room for evaluation, and was subsequently admitted. He was discharged from the hospital on June 9, 2009 and returned home. On July 27, 2009, HRA initiated an onsite investigation to determine compliance with federal and local standards of care with respect to the provision of health care, wound care and prevention and the establishment and implementation of policies and procedures designed to ensure client health and safety. The findings of this report were based on observation of Client #1, interviews with nursing staff, direct support staff and administrative staff as well as the review of the client's medical and physical therapy records. In addition, the client's incident reports and corresponding investigation reports also were reviewed. It should be noted that Client #1's health care and habilitation services had been reviewed during a March 19, 2009 annual recertification survey.	W 000	All staff were inserviced on client #1's repositioning on Refer to attachment #1 The repositioning form was revised by the facility RN. The RN did add the comment section in the event that there is discrepancy in repositioning time. Refer to attachment #2 In the future, the facility will ensure that client #1 is repositioned, and that any discrepancy in time is documented; in addition, the facility will only maintain one log book. It can be noted that the staff closed the door for privacy as they were about to provide care to client #1.	7-29-09 9-11-09
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by:	W 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 Based on observation, interview and record review, the qualified mental retardation professional (QMRP) failed to develop and implement a system to verify that clients were repositioned in accordance with their repositioning schedule, as prescribed, for the one client with multiple pressure sores out of five total residents. (Client #1) The findings include: On July 27, 2009 at 8:35 a.m., Client #1 was observed lying in bed, positioned on his back facing the ceiling. At the time, there was an LPN and at least two direct support staff on duty in the facility. The LPN stated that she had been on duty since approximately 8:00 a.m. that morning, in accordance with her scheduled shift. According to staff, and later verified through record review, Client #1 was totally dependent on staff for repositioning. At approximately 8:50 a.m., the house manager arrived in the facility. At 8:55 a.m., someone closed the client's bedroom door as this surveyor walked towards the door. The client's position at that time was not determined immediately. At approximately 9:30 a.m., the LPN stated that the client had a wheelchair and he was sitting in it at that time. [This was confirmed through observation.] She further indicated that there was an established schedule for repositioning him around the clock. Staff used the same positioning schedule every day. At approximately 4:55 p.m., review of a repositioning schedule posted on a wall next to the client's bed revealed that he should have been transferred from his bed into his wheelchair at 8:00 a.m. His orders were to have him repositioned every two hours.	W 159	All staff were inserviced on client #1's repositioning on Refer to attachment #1 The repositioning form was revised by the facility RN. The RN did add the comment section in the event that there is discrepancy in repositioning time. Refer to attachment #2 In the future, the facility will ensure that client #1 is repositioned, and that any discrepancy in time is documented; in addition, the facility will only maintain one log book. It can be noted that the staff closed the door for privacy as they were about to provide care to client #1.	7-29-09 9-11-09

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W 159	Continued From page 2 Beginning at approximately 4:57 p.m., the QMRP and the supervisory RN were asked about the repositioning schedule. To their knowledge, staff had been adhering to the posted schedule. They were not aware of any delays or variations in his repositioning. After hearing that the client had been observed in his bed that morning after 8:30 a.m., the RN telephoned the house manager to ask about it. She confirmed that he had been in bed at the time she arrived that day. Direct support staff had just returned to the facility from the morning van run to clients' day programs. They closed his bedroom door for privacy during personal hygiene care and then placed the client in his wheelchair afterwards. At approximately 5:12 p.m., review of two log books that were being maintained simultaneously by direct support staff revealed that neither log required staff to document the time that they actually performed the repositioning. Instead, the log sheets had a designated time and position already noted. Staff only had to place their initials in a space next to that repositioning. Review of the log sheet for that morning revealed that staff had placed their initials next to the 8:00 a.m. wheelchair repositioning, even though observations and interviews had shown that the client remained in bed until 8:50 a.m. or shortly thereafter. The QMRP and the RN acknowledged that they would not have known about the discrepancy in repositioning time had it not been brought to their attention by this surveyor. After more discussion, the QMRP and the RN acknowledged that the current method used by staff to document repositioning did not ensure accurate data for quality assurance purposes.	W 159	All staff were inserviced on client #1's repositioning on Refer to attachment #1 The repositioning form was revised by the facility RN. The did add the comment section in the event that there is discrepancy in repositioning time. Refer to attachment #2 In the future, the facility will ensure that client #1 is repositioned, and that any discrepancy in time is documented; in addition, the facility will only maintain one log book. It can be noted that the staff closed the door for privacy as they were about to provide care to client #1.	7-29-09 9-11-09

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W 159	Continued From page 3 It should be noted that Client #1 had pressure sores on the sacrum, right hip and left hip. A July 16, 2009 report from the wound clinic indicated that those three wounds were improving. There was no change with the fourth wound (right heal). It should be further noted that the physical therapist had determined 9 months earlier, in October 2008, that the seating system in the client's wheelchair did not meet the client's needs.	W 159	719-A form was sent to Essential rehab on 6-10-09; however, Essential Rehab did not deliver the wheelchair due to the fact that there was no record of the age of the wheelchair Refer to attachment #3. Another 719-A form was completed, and sent to Essential Rehab on 9-14-09 Refer to attachment #4 In the future, the facility will ensure that client #1 is provided with the adaptive equipment on a timely manner as prescribed by the PT.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to secure timely a custom seating system to meet a client's assessed needs, for the one client in the sample. The findings include: On July 27, 2009 at 9:30 a.m., Client #1 was observed seated in a wheelchair in his bedroom. There were pillows placed between both sides of his torso and the right and left sides of the chair. Beginning at 12:31 p.m., review of the client's physical therapy (PT) documents revealed that on November 17, 2008, the PT recommended a "new custom seating system" for his wheelchair. The PT then submitted an assessment tool dated December 29, 2008 that provided specifications	W 436		

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W 436	Continued From page 4 regarding the wheelchair molding. Attached was a December 28, 2008 Functional Mobility Evaluation on which the PT wrote "The seating system is oversized and does not support him. The frame is oversized and forces malalignment <sic>." Beginning at approximately 11:40 a.m., review of the qualified mental retardation professional's (QMRP's) monthly notes revealed for the period January 2009 - June 2009 revealed no references made to the wheelchair and there was no written documentation of efforts made to secure the new seating system. At approximately 1:15 p.m., the Director of Nursing and the QMRP were asked about the status of the custom-molded seating system for the client's wheelchair. They stated that as of July 27, 2009 he was without the new seating system. A form 719A reportedly had been submitted; however, they could not recall the exact date. They agreed to search for documentation. On July 28, 2009 at 10:35 a.m., the house manager stated that she had instructed staff to hand deliver a 719A form to the Primary Care Physician's (PCP) office; this reportedly was achieved on or around July 15, 2009, eight months after the PT recommendation. No written documentation was made available for review before the investigation ended at 5:10 p.m. that evening. It should be noted that in addition to the pressure ulcer on his right heel, Client #1 was receiving treatment for a pressure ulcer on his right hip, another ulcer on his left hip and yet another	W 436	719-A form was sent to Essential rehab on 6-10-09; however, Essential Rehab did not deliver the wheelchair due to the fact that there was no record of the age of the wheelchair Refer to attachment #3. Another 719-A form was completed, and sent to Essential Rehab on Refer to attachment #4 In the future, the facility will ensure that client #1 is provided with the adaptive equipment on a timely manner as prescribed by the PT.	9-14-09

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W 436	Continued From page 5 pressure ulcer on his posterior sacral area.	W 436		